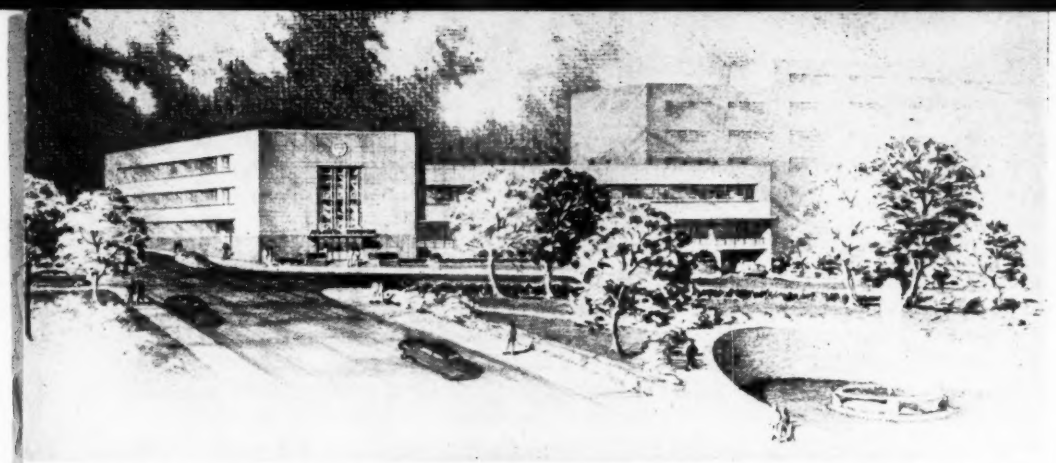


THE ATLANTA ECONOMIC REVIEW

APRIL, 1954
VOL. IV NO. 4

Published monthly as a service to Atlanta citizens by the Division of Research, School of Business Administration, Atlanta Division, University of Georgia.

ECONOMIC TENETS OF HOSPITAL CHARGES

by

JAMES M. SITTON*

Introduction[a]

The cost of hospital care is a matter which is of increasing interest and concern to the American public, for one out of every eight persons in the United States will enter a hospital during the coming year.[1] Hospital service is a necessary component of our standard of living, and public cognizance of the value of good medical care is largely responsible for the demand for the extension of hospitalization.[2] Yet, many people have only a superficial knowledge of the economic basis of hospital charges and a restricted concept of the function and complicated organization of hospitals, both of which are usually gained under the unnatural stress of illness.[3]

Hospital charges may be said to be the selling price of hospital care which should be based on costs to the individual institution of rendering the services. Generally speaking, it is the consumer's cost of procurement of hospital care and the institution's income for providing services.

An analysis of hospital charges demands some consideration of costs from three different approaches: (1) the charges to the individual patient or his sponsor, (2) the interplay of institutional income and expense from the standpoint of hospital management, and (3) the problems of society relative to hospital finance. A direct economic relationship exists between hospital charges, hospital cost, hospital income, and hospital services. Thus, all these factors must be introduced into any valid discussion of hospital charges.

a. See footnotes at end of article.

*Mr. Sitton is Associate Director Division of Hospital Services, Georgia Department of Public Health. He is a junior at the Atlanta Division of the University of Georgia, evening session, and is majoring in Economics.

Factors Influencing Hospital Care

The cost level to hospitals of providing services tends to be determined or materially influenced by: (1) the level of the general price index, (2) the trends in medical care, and (3) the level of utilization of the facility.

The cost of hospital care is influenced by the fact that the hospital expends its money in a competitive market; thus, the cost of hospital care tends to vary directly with the level of the cost-of-living. The general price index affects the cost of recruiting and retaining staff personnel, the cost of the procurement of supplies, the cost of the modernization of the plant, and the cost of replacement of equipment.

Of particular significance is the impact of the costs relative to personnel services. In this category, which accounts for between 60 and 70 per cent of cost,[4] the hospital not only engages in a struggle to prevent industry from attracting its personnel but engages in direct competition with other hospitals in fulfilling its staff requirements. This competitive labor struggle linked with the acute shortage of professional personnel has resulted in an additional cost burden in salaries and wages. Furthermore, individual pay increases to the traditionally underpaid employees in hospitals become a significant cost element when consideration is given to the fact that in 1950 the national average for hospitals was 1.78 employees for each patient bed.[5] Also, when individuals change employment, the hospital sustains the resultant hidden but additional cost—the cost of personnel turnover.

The cost of hospital care is influenced by the trends in medical care. New developments in medical science—the improvements in surgical techniques, the refinements in the use of anesthesia and

intravenous medications, the application of antibiotics and other therapeutic agents—tend to reduce the period of hospitalization and to enhance the chance of recovery.[6] Each new development or improvement in medical science means more effective medical care to the patient; however, intensive and more effective care usually means a higher cost for hospital service. An outstanding example of intensive care is the use of recently developed medicaments such as penicillin, aureomycin, terramycin, cortisone, the antihistamics, and radioactive substances (isotopes)— which are effective but costly. The manufacturers of these products state that the initial selling price on a new preparation is likely to be high because the research cost in discovering and producing the substance may be as great as three to five million dollars before a single vial or unit is sold.[7] Hospital costs, therefore, indirectly include a pro-rata of this research expenditure.

The cost of hospital care is influenced by the utilization of the facility in two ways: (1) through a cost known generally as "readiness-to-serve," and (2) through additional costs which may be attributable to a fluctuating percentage of occupancy. Readiness-to-serve is the cost element which is similar to the conventional term "overhead"; actually, it is the fixed cost of keeping the hospital open and ready to serve at all times and to a large degree is independent of the number and types of patients admitted for care. Too low an occupancy rate affects costs adversely because available resources are not fully utilized. Fluctuations in the percentage of occupancy, like readiness-to-serve, means uneconomic use of personnel, supplies, and equipment. Nevertheless, these costs are logical components of hospital charges because the hospital, like the fire department, must be ready twenty-four hours a day and seven days a week to serve, on a moment's notice, patients who may have any number of varieties of illnesses or injuries.

Factors Influencing Hospital Income

Hospital income means gross revenue from all sources. The two principal channels of such revenue are (1) payments for service rendered and (2) income from benevolent and miscellaneous sources.[8] Payments for service rendered includes income from private-pay patients, income from part-pay patients, third-party payments through the insurance principle, and third-party payments for indigent care. Benevolent and miscellaneous sources include grants, contributions, endowments, and gifts as well as income from auxiliary functions such as the flower shop, snack bar, or similar activities.

The level of hospital income tends to be determined or materially influenced by: (1) the availability of consumer purchasing power, (2) the extent of philanthropy, (3) the policy of the individual hospital relative to rates and charges, (4) the level of utilization of the facility, and (5) the prevailing philosophy relative to third-party payments.

The level of consumer purchasing power affects hospital income in two ways: namely, by the demand for hospital care and ability to pay for such care. During periods of relative prosperity, the consumer has more income with which to pay for hospital services or hospitalization insurance.[9] This fact is probably the basis for an increasing demand for the more expensive private and semi-private rooms and services, and a decreasing demand for ward accommodations.

The effect of philanthropy on hospital income appears self-explanatory; however, some comment on the change in dependence on this source seems indicated. Several decades ago, public spirited citizens financed hospital service as a charitable function for the benefit of the medically-indigent segment of the population.[10] Contributions are one of the means by which the hospitals have continued to maintain their existence; however, in recent years, "philanthropy, under the burden of heavy taxation, has tended to decrease the availability of its funds to hospitals."[11]

The policy of the individual hospital relative to rates and charges affects hospital income primarily in the following ways: (1) charges to patients are

ATLANTA ECONOMIC REVIEW

Published monthly by the

Division of Research, School of Business Administration
Atlanta Division, University of Georgia
24 Ivy Street, S. E., Atlanta 3, Ga.

School of Business Administration

George E. Manners, Dean

Division of Research

John P. Gill, Ph.D., Director of the Division and Editor of the Atlanta Economic Review
William H. Wells, Statistician
Shirley Thompson, Secretary

Committee on Research

John P. Gill, Chairman
Harold L. Johnson
Marvin Tummins
Willys R. Knight

Subscription to
ATLANTA ECONOMIC REVIEW

The ATLANTA ECONOMIC REVIEW is sent free of charge to anyone interested in receiving it. If you are not already on the mailing list and wish to receive the REVIEW regularly, please write to the Division of Research, Atlanta Division, University of Georgia, Atlanta, Georgia.

quite frequently not related to the cost of services rendered, (2) adjustments on patients' accounts are often made when the individual is unable by any reasonable means to pay the full charge for hospital care, and (3) discounts to employees of the hospital and to medical and related professional people are quite common. The underlying reason that charges are not always related to cost stems from the fact that the majority of hospitals do not give proper consideration to cost accounting and cost analysis. Super-imposed on this condition is the fact that hospitals have traditionally undercharged all types of patients for "room and board" and attempted to counter-balance this discrepancy by overcharging for extras—the operating room, anesthesia, laboratory, x-ray, and other service activities.

The prevailing philosophy relative to third-party payments affects hospital income because in recent years a substantial percentage of hospital income has been paid on behalf of the patient by such entities as insurance plans, foundations, governmental agencies, and similar organizations. The aggregate of these sources of income is referred to as third-party payments. However, all third parties do not employ a consistent basis for the payment of hospital care—a few pay full costs, some pay an established percentage of cost, and others pay predetermined flat rates.[12] Furthermore, "it is a historical fact that governmental agencies have been reluctant to absorb the full costs of welfare service formerly provided by private philanthropy."[13] It appears that there is a widespread prevalence of this condition at the local level where community officials wish to assume only in part the obligation for indigent care.

Hospital Charges from Viewpoint of Hospital Management

Hospital management, like any commercial venture or business, must secure sufficient income to cover the total costs. No economic activity, including hospitals, can long endure the pressure of a mounting or continuous deficit. However, hospitals are continually confronted by professional groups with demands for improvement in services which costs must be balanced against the hospital budget and the financial ability of the patient.[14] Individuals responsible for the continued operation of our hospitals are expected to raise standards of care, to render services to more people and to absorb an increased cost of operation, whether due to expanded services or the economic index; yet, these objectives are to be accomplished without increasing hospital charges.[15]

Hospital services are not limited to those customers who are able to pay the full costs of the service they receive. This fact is based on the concept that care during illness or injury is the right of all people, regardless of their ability to pay.[16] Yet, all care costs money and if the individual is unable to pay, the hospital must turn to other sources to make up the difference. "The greatest portion of the burden, thus far, has been carried by the individual private patient."[17] Also, indirectly the hospital's creditors and hospital employees may be forced to bear part of the cost of free service by granting extended credit and by receiving salaries which are below the going market for similar work.[18]

Generally speaking, services and equipment are utilized more intensively on behalf of the patient during the early part of a period of hospitalization. To the patient, this concert of effort may mean a shorter hospital stay, a reduction in cost of total illness, and an opportunity to return to gainful employment more rapidly.[19] However, an increased ratio of acutely ill patients to the total census tends to influence adversely the gross expenditures of the hospital and the cost of per patient day.

Hospital charges are not amenable to the customary price practices of business. This is true because a business venture seeks to exchange its services and goods with the primary motive of monetary gain; however, a hospital seeks to render service, collecting money only as a necessary function to its existance.

Hospital management apparently feels that the public places too much emphasis on the cost per patient day and not sufficient attention to the cost per patient stay. It is claimed that a higher per diem charge is in the patient's interest because such increase in daily costs are due to more intensive treatment and a shorter period of hospitalization. The cost per patient stay needs to be stressed since it reflects the monetary cost to the patient for care during an illness. This cost per illness gives consideration in comparison to the shorter periods of stay of the patients. The following table is presented to depict to some degree the validity of the statement that the cost per patient day is not a sound means of determining trends in hospital costs and that the unit of measure of hospital charges

Hospital Trends, 1900-1950

Year	Average Length of Stay Days	Average Cost Per Patient-Day	Average Cost Per Patient	Cost-of Living Index*	Adjusted Average Cost Per Patient
1900	32.0	$ 1.19	$38.08	55.0	69.24
1920	12.9	3.71	47.85	143.3	33.39
1940	11.2	4.91	54.88	100.2	54.77
1944	9.9	6.57	64.90	125.7	51.63
1950	8.1	15.62	126.52	171.9	73.60

*1935-1939 equals 100.

MARCH
ATLANTA AREA ECONOMIC INDICATORS

ITEM	March 1954	February 1954	% Change	March 1953	% Change
EMPLOYMENT					
Job Insurance (Unemployment) Payments	$394,335	$311,187	+26.7	$152,783	+158.1
Total Non-Agricultural Employment	296,200	296,050*	+0.1	294,400	+0.6
Manufacturing Employment	78,700	78,900*	−0.3	77,950	+1.0
Average Weekly Earnings, Factory Workers	$60.45	$61.62	−1.9	$62.78	−3.7
Average Weekly Hours, Factory Workers	39.0	39.5	−1.3	41.3	−5.6
Number Help Wanted Ads	6,359	5,866	+8.4	10,555	−39.8
Estimated Unemployment	9,350	8,450**	+10.7	6,000	+55.8
Percent Labor Force Unemployed	2.7	2.4	—	1.7	—
CONSTRUCTION					
Number Building Permits City of Atlanta	9.74	700	+39.1	1,002	−2.8
Value Building Permits City of Atlanta	$4,339,019	$4,896,349	−11.4	$4,442,548	−2.3
Employees in Contract Construction	14,900	14,650*	+1.7	13,400	+11.2
FINANCIAL					
Bank Debits (Millions)	$1,359.2	$1,180.6	+15.1	$1,282.9	+5.9
Total Deposits (Millions) (Last Wednesday)	$941.9	$952.1	−1.1	$946.2	−0.5
POSTAL§					
Postal Receipts	$1,495,640	$1,301,894	+14.9	$1,280,575	+16.8
Poundage 2nd Class Mail	1,393,189	1,275,733	+9.2	1,271,381	+9.6
OTHER					
Department Store Sales Index (Adjusted) (1947–49=100)	120	116	+3.4	121*	−0.8
Department Store Stocks	N. A.	N. A.	+6.0	N. A.	−1.0
Consumer Price Index (1947–49=100)	117.0	—	—	116.7	+0.3
Retail Food Price Index (1947–49=100)	112.2	112.5	−0.3	112.3	−0.1
Number Telephones in Service	245,508	244,901	+0.2	235,790	+4.1

*Revised. N.A.—Not Available. **Jan., 1954.
§City of Atlanta only.

Sources: All data on employment, unemployment, hours, and earnings: Employment Security Agency, Georgia Department of Labor; Number Help Wanted Ads: Atlanta Newspapers, Inc.; Building permits data: Office of the Building Inspector, Atlanta, Georgia; Financial data: Board of Governors, Federal Reserve System; Postal data: Atlanta Post Office; Retail Food Price Index: U. S. Department of Labor; Department Store Sales and Stocks Indexes: Federal Reserve Bank of Atlanta and Board of Governors, Federal Reserve System; Telephones in Service: Southern Bell Telephone and Telegraph Company.

JANUARY THROUGH MARCH, 1953 and 1954

1954	1953	ITEM	PER CENT CHANGE
$4,091,615	$3,554,414	Postal Receipts, Atlanta Post Office	+15.1
14,650	13,100	No. Construction Employees*	+11.8
3,814,151	3,441,452	Poundage 2nd Class Mail Atlanta Post Office	+10.8
$3,730,080	$3,493,819	Bank Debits (Millions)	+6.8
245,508	235,790	Telephones in Service**	+4.1
78,750	77,200	No. Manufacturing Employees*	+2.0
296,350	292,900	Total Non-Agricultural* Employment	+1.2
$62.59	$62.12	Average Weekly Earnings,* Factory Workers	+0.8
117.0	116.7	Consumer Price Index City of Atlanta (March)	+0.3
112.2	112.3	Retail Food Price Index (March)	−0.1
$941.9	$946.2	Total Deposits (Millions)**	−0.5
N. A.	N. A.	Department Store Stocks**	−1.0
39.8	41.1	Average Weekly Hours, Factory Workers*	−3.2
N. A.	N. A.	Department Store Sales (Based on dollar amounts)	−5.1
2,436	2,694	Number Building Permits City of Atlanta	−9.6
$12,652,833†	$15,657,353	Value Building Permits, City of Atlanta	−19.2
19,054	29,049	Number Help Wanted Ads	−34.4

†Special ruling permits construction of $20,500,000 Grady Hospital addition without permit. If included, total above is $33,152,833 and the change becomes plus 111.7%.
*Average month.
**End of period.
N.A.—Not Available.
Sources: Same as page 4.

should be the cost per patient stay:[20]

A hospital, unlike a business concern, does not possess the freedom to add or to discontinue activities based solely upon the decisions of management or upon the desire or ability of the patients to purchase that service.[21] The physicians, who are divorced from the direct financial responsibilities of the hospital, are the predominant influences in the determination of the scope and nature of the services of the hospital. Thus, the economic level of hospital charges is inversely affected by "the inflexibility of the standards which modern medical practice has set up for hospital care."[22] Furthermore, hospital services are a contra-uniform product which may involve obstetrics, normal to complicated; surgery, appendectomy to thoracoplasty; medical, minor upper respiratory infections to hypertensive vascular conditions; psychiatrics; and communicable diseases. Thus, hospital care is not amenable to the economic principles of mass production or optimum utilization, but the hospital is compelled to bear a heavier "unit cost" because of the necessity of individual service to patients by highly trained personnel.

The consumer's option of quality, which is common in business practice, is not adaptable to the field of hospital care. There is only one acceptable quality of hospital service and that is the highest quality obtainable by the institution. Thus, the hospital, unlike a business, cannot select a quality level which cost is consistent with the consumer's effective demand. The quality of hospital care is based upon the needs of the consumer and not upon his effective demand or his desires.

Hospital Charges from the Viewpoint Of the Individual Consumer

The consumer of hospital services desires the best hospital care for the lowest possible price. The consumer is cognizant of the fact that the cost of hospital services is high, but frequently believes that the charges for hospital care are excessive. The charges for hospital care seem relatively high to the patient when an attempt is made to pay the hospital bill and current household expenses from current personal income. Quite frequently, the economic consequence of a period of hospitalization to the patient or his family is reduced income and increased expenses.

The uncertainty of illness and accident tends to complicate the matter of hospital care for the consumer. "The nature, occurrence, duration, and severity of individual cases of illness and accident cannot be predicted."[23] Since need for hospitalization usually comes unexpectedly, the expense of hospital care cannot be foreseen by the consumer. Lack of knowledge of a contingent demand on his resources places the consumer in a position which renders budgeting for hospital care difficult or perhaps impossible.

The consumer's attitude toward hospital charges is also affected by the managerial policies of individual hospitals. This attitude is generally adversely affected by such practices as the requirement to pay a "deposit" in advance of admission and the inclusion in the hospital bill of additional charges for minor medications or services. Furthermore, the consumer is not always satisfied with the personal attention and level of service provided by the hospital, particularly is this true when it is felt that the service is being paid for and thus a service which the patient is entitled to receive.

Other than utilizing savings or by borrowing, the consumer may guard against the costs of hospitalization through a prepayment plan operated on an insurance basis. Through such a plan, regular payments in the form of insurance premiums can be budgeted in a manner similar to other household expenses. The effect of hospitalization insurance is that of substituting average premium costs for variable and uncertain hospital charges.[24] However, there are several types of prepaid hospital insurance, and the premium payments and the resultant benefits are even more numerous. The consumer must be alert to these variations in types of hospitalization insurance and he must avoid being sold just any "hospital policy" on the pretext that it will cover full expenses when hospital care is needed.

Hospital care is a peculiar service, in that it would be better for the consumer if he did not need it; "hospital service is not something to be enjoyed for itself as a part of basic human functioning."[25] Thus, in the procurement of hospital services, the consumer pays for an economic good which he would prefer not to purchase. Furthermore, hospital care is a contra-uniform product which possesses individual characteristics and requires a high level of specialized knowledge to render. Thus, the expenditure for hospital care covers services about which the consumer has only superficial knowledge. Perhaps these two factors help account for the fact that the hospital, from time to time, is accused of charging exorbitant prices for its services.

Problems of Society Relative to Hospital Charges

Society as a whole demands the continuation of hospital services as a necessary component to our standard-of-living; yet, with too few exceptions, our hospitals are in serious financial straits.[26] "The financial problem of the hospital is due, in large part, to a lag between the upward movements in costs of services and the willingness and ability of the consumer of services to pay the bill."[27] The increase in cost of providing hospital care should not cause as much concern to society as the need to find a way to meet current financial problems. Advances in hospital costs when due to more effective care are not necessarily a social or economic

calamity for the socio-economic product of a hospital is a group of recovered or improved patients.[28]

Although hospital care may be considered expensive, society should not overlook the fact that in 1951, the American public was paying five times as much for cigarettes and tobacco as it did for hospital care and nearly three times as much for soft drinks and chewing gum as for hospital services.[29]

Probably the most significant development of the last quarter of a century in the field of medical economics, from the standpoint of society, is the Blue Cross Plan for group payment of hospital bills; yet, even with the insurance principle, hospital income has remained unstable because of the inability or unwillingness of some of the non-insured population to pay full cost.[30] In fact, the insurance principle "does not meet the needs of the families whose income is already too hard pressed by a minimum standard-of-living, or who have no income at all, unless the premium payments can and will be made on their behalf from other sources, whether industry, philanthropy, or government."[31]

On the other hand, society is probably aware that government has used tax funds to pay hospitals for the care of patients for whom public agencies have assumed responsibility. Even though government does not pay full costs, payment for services through taxation has the net effect of supplementing hospital income. This is true because if government did not assume some responsibility for these patients, the hospital would have to carry the entire burden of the cost of services to these individuals rather than recovering a substantial portion of cost. Nevertheless, the government should not receive preferential consideration when purchasing hospital care but it should pay full cost for all patients receiving care under its sponsorship.

The hospital of several decades ago frequently influences current opinions and attitudes of society relative to the method of financing of hospital care. "Their concept of the hospital as a charitable institution, whose costs are met in part by paying patients but largely by philanthropic contributions and charity, is no longer valid. The hospital of today tends to be a non-profit community agency whose income depends primarily on earned revenue."[32] Thus during the past few decades, the burden of financing hospital care has shifted from philanthropic contributions to the patients or their sponsors. Yet, financing of hospital care dependent upon earned revenue apparently has never been adequate. Society has been lax in demanding the development of a sound method of hospital finance. In fact, the hospital of today is vulnerable to state control because of the demand for its services from all classes of society and the immediate costliness of these services.

Society is thus at the crossroads of decision in determining the method of future financing of hospital care. In other words, a totally new concept of hospital finance must be developed. Such a method must assure the hospital that costs will be fully recovered and must assure the consumer relief from undue and uncertain burden; yet, this must be achieved without lowering the high standards of hospital care. Basically, the choice is between government-sponsored compulsory insurance and voluntary prepayment insurance plans; however, the development of an approach is possible which utilizes both government and private enterprise, each with fixed areas of responsibility.

Summary

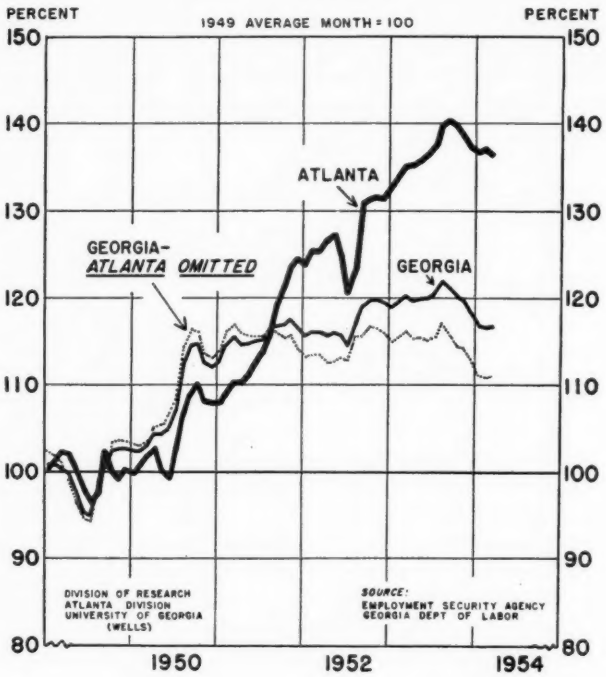
In summary, the average cost per patient day is increasing; yet, the average cost per patient stay is generally consistent with the level of the cost-of-living index. The shorter stay in the hospital is in the patient's interest; however, the first few days of service is the most costly period for the hospital. Gifts and contributions to hospitals are decreasing; and third-parties, including governmental agencies, are reluctant to pay full cost. Hospitals are compelled to grant some gratis service; yet, there is no such thing as free hospital care. All services must be paid for by some means if the hospital is to continue to exist. Thus, the hospital is faced with a financial crisis. A totally new concept of hospital finance is indicated. Such a method must assure the hospital that costs will be fully recovered without any undue burden on any patient; yet, this must be achieved without placing our medical care system under governmental control and without lowering the high standards of hospital care.

FOOTNOTES

1. Raymond P. Sloan, *This Hospital Business of Ours*, New York: G. P. Putnam's Sons, 1952, p. 19.
2. Arthur C. Bachmeyer and Gerhard Hartman, *Hospital Trends and Developments*, 1940-1946, New York: The Commonwealth Fund, 1948, preface.
3. Nathaniel W. Faxon, *The Hospital in Contemporary Life*, Cambridge, Massachusetts: Harvard University Press, 1949, preface.
4. *This Hospital Business of Ours*, p. 21.
5. U. S. Government, Federal Security Agency, Public Health Service, *Hospital Dollars and Facts*, (January, 1952), p. 22.
6. *The Hospital in Contemporary Life*, p. 266.
7. R. Cragin Lewis, "The Truth About Costly Drugs," *Medical Economics*, (May, 1951), pp. 74-79.
8. *The Hospital in Contemporary Life*, p. 267.
9. W. B. Bryant, "Focus on Tomorrow's Hospital Costs," *Hospitals*, (February, 1953), pp. 62-65.
10. C. Rufus Rorem, "Why Hospital Costs Have Risen," *Hospital Management*, (December, 1950), pp. 40-42.
11. *Hospital Trends and Developments*, 1940-1946, p. 26 and p. 51.
12. "The Principles of the Third-party Payments for Hospital Care," *Hospitals*, (July, 1951), pp. 37-39.
13. *Hospital Management*, (December, 1950), pp. 40-42.
14. Albert W. Snoke, "Three Viewpoints on Hospital Costs," *Hospitals*, (December, 1951), pp. 50-52.

15. Harry Becker, "Third Party Payer in Future Financing of Hospital Care," *Hospital Management*, (March, 1952), pp. 65-68.
16. George E. Bair, "Factors That Influence Free Service," *Modern Hospital*, (January, 1952), pp. 90-96.
17. *Hospital Management*, (December, 1950), pp. 40-42.
18. *Modern Hospital*, (January, 1952), pp. 90-96.
19. *Hospitals*, (February, 1953), pp. 62-65.
20. *Hospital Dollars and Facts*, p. 15. The column "Adjusted Average Cost Per Patient" was added by the writer of this paper and is based on 1935-39 constant dollar.
21. Eli Ginsburg, *A Pattern for Hospital Care*, New York: Columbia University Press, 1949, p. 72.
22. Robert F. Whitaker, "Why Your Hospital Bill is So High," *The Atlanta Journal* Magazine, (January 9, 1949), pp. 4-5.
23. Persia Campbell, *The Consumer's Interest: A Study In Consumer Economics*, New York: Harper and Brothers, 1949, p. 375.
24. *The Consumer's Interest: A Study In Consumer Economics*, p. 376.
25. *The Consumer's Interest: A Study In Consumer Economics*, p. 367.
26. The Atlanta *Journal* Magazine, (January 9, 1949), pp. 4-5.
27. *Hospital Management*, (March, 1952), pp. 65-68.
28. Harry Becker, "Financing Hospital Care," *Southern Hospitals*, (May, 1953), pp. 27-36.
29. *This Hospital Business of Ours*, p. 22.
30. *Hospital Management*, (December, 1950), pp. 40-42.
31. *The Consumer's Interest: A Study in Consumer Economics*, p. 365.
32. *Southern Hospitals*, (May, 1953), pp. 27-36.

RELATIVE GROWTH IN FACTORY EMPLOYMENT GREATER IN ATLANTA THAN IN REST OF GEORGIA.....



Atlanta Division
UNIVERSITY OF GEORGIA
24 Ivy Street, S.E.
Atlanta 3, Georgia

RETURN POSTAGE GUARANTEED